

Mental Retardation Community Medicaid Services

____ New
for CSP Year

____ Revision
for CSP Year

INDIVIDUAL SERVICE PLAN

Estimated Duration: _____

Indicate Service: ____ Residential Support ____ Supported Employment ____ Day Support ____ Prevocational

Individual: _____ Medicaid Number: _____

Code: _____ Provider Name: _____ Provider Number: _____

Responsible Staff (name or position of implementer of the plan): _____

Start Date: _____ End Date: _____ Quarterly Review Dates: _____

Goals/objectives are based on up-to-date assessment information present in the file.

CSP SELECTED GOAL/ DESIRED OUTCOME:

OBJECTIVES	TARGET DATE	ACTIVITIES/ STRATEGIES

SUGGESTED FORM

Individual: _____ Service: _____ Start Date: _____

OBJECTIVES	TARGET DATE	ACTIVITIES/ STRATEGIES

SUGGESTED FORM

Individual: _____ Service: _____ Start Date: _____

OBJECTIVES	TARGET DATE	ACTIVITIES/ STRATEGIES

SUGGESTED FORM

Individual: _____ Service: _____ Start Date: _____

TOTAL HOURS/ UNITS PER WEEK _____

GENERAL SCHEDULE OF SERVICES

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

NOTE: Day Support, Prevocational and Group Model Supported Employment Services are limited to 780 units per year. This includes combinations of any of the above, as well as combinations that include Individual Competitive Supported Employment.

COMMENTS:
(Role of other agencies if plan a shared responsibility)

**Attach a signature page that includes, at a minimum, the signatures of the individual/legal guardian and the provider's responsible staff member.*